# HHA PPS MAILBOX QUESTIONS

## *VOLUME I: DECEMBER 2000 AND JANUARY 2001 – Batch 1*

**The questions below, which in some cases have been paraphrased, were sent to: *HHPPSQuestions@HCFA.gov* during the period referenced above. It is our intention to continue to answer question that come into that mailbox in monthly batches, and post those answers at: *www.hcfa.gov/medlearn/refhha.htm.* For example, this first batch of questions was pulled from the mailbox prior to February 1, 2001, and we hope to post the answers on approximately March 1, 2001. A second batch of questions, labeled as Volume II, will be posted at a later point in that same month, since these questions required expertise beyond that of the claims processing staff managing the mailbox. Note that questions without broad applicability have been/will be answered/referred individually.**

**Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each volume of answers, and a table of cross-references will follow.**

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*** = question appears under this topic below**

## General Acronyms

**The following acronym may not be spelled out/explained above or elsewhere in this document:**

**HH =** home health
**HHA =** home health agency
**HCFA =** Health Care Financing Administration, the Federal Agency administering Medicare
**HHRG =** Home Health Resource Group, the payment group for HH PPS episodes
**HIPPS =** Health Insurance PPS, a code representing a PPS payment group on a Medicare claim, placed in Form Locator 44
**HCPCS =** HCFA Common Procedure Coding System, individual codes, representing medical services or items in Form Locator 44 of Medicare claims
**HIQA, HIQH =** Health Insurance Query Part A, Health Insurance Query Home Health, on-line inquiries and responses available through Medicare standard system software
**URL =** Uniform Resource Locator, addresses for finding information on the Internet.

# VOLUME I, Batch I, HH PPS Billing QUESTIONS and ANSWERS

**HH PPS and General Policy, Questions 1-14:**

**10/01/00 Transition:**

Q1. I have recently heard from NHCA that Medicare Fiscal Intermediaries are net ready for processing HH PPS final claims. Is this correct? If it is, when will HCFA be ready?

**A1. We believe this question has been superceded by events. Medicare Regional Home Health Intermediaries (RHHIs) have been able to process final claims since HH PPS software was brought up in Medicare systems October 30, 2000. Some systems problems have occurred since that time, and may have affected final claims, but HCFA, its software maintainers and the RHHIs continue to work these through as they arise. The scope of all these problems continue to be reduced as HH PPS operations continue. (03/02/01)**

Q2. We saw a 95 year-old patient admitted mid-September and discharged mid-October. Both the patient and his wife said he didn't have Medicare, that he was a Corps of Engineer employee, and had Federal Blue Cross coverage. We called Blue Cross before admitting him, and received benefit information, etc.

This week, we learned that this patient DOES have Medicare. He is eligible for Part A Medicare through his wife's contributions to Social Security.

My question is this: we have called Blue Cross, and they are now saying Medicare is primary. We didn't prepare the patient's plan of care (485) with two sets of orders, one each for September and October 2000, like as Medicare required because of the change to the PPS payment system for home care, because at the time we thought his only insurance was Blue Cross. We are going ahead and billing Medicare for his September claim, but what do we do about the October claim, since the 485 isn't with separate orders?

**A2. In the example above, physician orders did exist for the period October 1 through the mid-October discharge, Medicare was just not known to be primary. Therefore, assuming an OASIS assessment was also done, an episode still may be billed to Medicare for that period. However, the reason for failing to break the orders at October 1 as was required should be noted in the patient records. This can be allowed only in exceptional circumstances and is dependent upon the physician's orders having enough specificity and clarity to be interpreted for two periods of care.**

**In the example above, full episode payment would be received as long as the patient did not obtain home care elsewhere during the remainder of the 60-day period. Payment would be a LUPA episode if 4 or fewer visits were received during the HH PPS period. In general and beyond the transition of payment systems, it is known orders will sometimes not be given for a full 60-day period. Patients must be discharged at the end of the period the**

**orders cover OR new/revised orders must be obtained the cover the rest of the episode period. (03/02/01)**

**Payment Rates:**

Q3. When Medicare changes a rate (such as the MSA, Loss-Sharing Ratio, and PPS Standard Rate for services, Fixed Dollar Loss Amount, National Visit Rates, etc.), when do the changes take effect for an episode in progress? In other words, if the rates change occurs in the middle of an episode in progress are the rates that apply the new rates, or the ones in effect when the episode started (the claim From Date).

**A3. Given that the basic unit of payment that must be administered for HH PPS is an episode of up to 60 days, HCFA has instructed that entire episodes will be paid in accordance with the fiscal year in which they end. For example, an episode beginning September 15, 2001 and ending November 12, 2001 would be paid in total according to the rates in effect for fiscal year 2002.**

**Often, law requires rate changes. Law also stipulates when such changes will go into in effect. For example, the Benefit Improvement and Protection Act of 2000 (BIPA 00), passed in December of 2000, required rate changes for home health prospective payments going back to the inception of the system (October 2000). It was stated these changes would be implemented in the middle of the federal fiscal year (April 2001). Therefore, payments were increased in the second half of that year, so that cumulative payments would approximate those that would have been expected if the change had been able to be made at the beginning of the year.**

**If HCFA has flexibility in implementing a rate change for institutional providers like home health agencies, the change will usually be made effective at the beginning of the federal government fiscal year each October 1. The home health prospective payment system (HH PPS) began with the advent of the 2001 federal fiscal year, and to the extent possible, routine or annual updates to this system will be scheduled to become effective each October 1. For example, changes in inflation factors used in rates must be reviewed annually, and would be effective each October 1.**

**All the rate changes mentioned above, except for the change required for BIPA 00, are set forth in regulation and therefore require regulatory change. Changes affecting existing regulation, such as the regulations implementing HH PPS, must be published in a notice in the Federal Register. These notices must be done at least three months in advance of the expected effective date (i.e., no later than July 1 for October 1), so that Medicare Contractors, providers and other affected parties have time to implement. Such regulatory or even statutory changes will almost always be paralleled by instructions, usually in the form of Medicare Program Memoranda, issued by HCFA to Medicare contractors and available to the public on HCFA's website (*www.hcfa.gov*). (03/02/01)**

**Requests for Anticipated Payment (RAP):**

Q4. Can an agency file a RAP for a subsequent 60-day episode before a final claim has been billed for the initial 60-day episode (one episode is not connected to another episode)?

**A4. Yes, a request for anticipated payment (RAP) for a subsequent episode may be filed before the claim of the previous episode. For most HH PPS episodes, a RAP is billed to start an episode, and a claim is billed to close the episode. However, if a final claim is not filed within 120 days of the start at any episode, the RAP payment for that same episode will be recouped. (03/02/01)**

Q5. Please clarify timeframes for submission of HH PPS RAPs and claims, as we appear to be receiving variable interpretations of the Final Rule:

> Version 1: "The RAP will be cancelled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the RAP payment".
>
> Or Version 2: "If a final claim is not received 120 days after the Start of Care date or 60 days after the paid date of the RAP (whichever is greater) the RAP payment will automatically be cancelled:"

Do we have 120 days from the start of care, meaning the From Date on the RAP and the claim for the episode in Form Locator 6, to file our final claim, or do we have 60 days from the end of the episode? Please clarify.

**A5. Many providers have confused the timing of when requests for anticipated payment (RAPs) and claims can be submitted and the time frame in which RAPs will be recouped and automatically cancelled if not followed by a claim.**

**The timely filing limits for claims did not change under HH PPS; therefore, there are 15-27 months to file a claim, depending on the month in which services were delivered. A RAP could be filed-- and paid-- for a long as a claim could be filed for the same episode. If the RAP is automatically cancelled because the final claim was not received within the recoupment time frame, the RAP can then be re-submitted at any point in the balance of the 15-27 months.**

**The RAP itself will be cancelled, if not followed by a claim for the same episode after a certain period, the time frame for RAP recoupment. This is described in current Medicare instructions as follows:**

> **the RAP will be cancelled and [its payment] recovered [against other billings] unless the claim [for the same episode] is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the payment of the RAP.**

**To clarify further, the RAP will not be auto-cancelled until the later of 120 days from the start of the episode or 60 days from when the RAP is paid, whichever occurs later in time.**

**Note that Medicare claims processing systems have been having difficulty processing claims submitted on the day the RAP is due to be auto-canceled for the episode represented by the claim. While a fix is being worked on, HCFA and the Regional Home Health Intermediaries (RHHIs) are encouraging providers to submit their claims earlier than the auto-cancel date if at all possible. (03/02/01)**

Q6. In what cases would there be $0 reimbursement for the submitted RAP?

**A6. The most common case is when a request for anticipated payment (RAP) is submitted and there is a primary payer before Medicare. In such Medicare secondary payment (MSP) situations, no payment will be made on the RAP, though the RAP can be submitted and will be processed to completion for 0% payment, so that the home health agency can be recorded as the primary agency for that beneficiary for the episode period. The full Medicare responsibility for the episode, which will take into account how much the primary payer paid in the episode period, will be made when the claim is received after the end of the episode.**

**Another case in which RAPs may be paid at 0% is if the provider submitting the RAP has been determined to be suspect for suspension of RAPs. Payment of the RAP can be suspended with cause, when a significant Program Integrity problem has been identified, leaving such providers to receive payment in full when their claims for episodes are processed. (03/02/01)**

**Medicare Secondary Payer (MSP):**

Q7. Since HH PPS began, I have had two clients for whom I submitted RAPs that came back denied because they were said to be MSP claims. However, I have written statements from both parties stating they have never had the insurance that is listed as primary, and Medicare has always been primary for them. I have tried going into FISS to find the RAPs and correct them by removing MSP information, but I cannot find them. I have tried to create MSP RAPs on my PC-ACE software (Medicare supplied billing software), but the software will not accept what I create. I don't know who to call at this point or what to do. Do you all know what I should do to get these claims paid?

**A7. If you believe the information in Medicare's Medicare secondary payer (MSP) records are in error, please contact your Regional Home Health Intermediary (RHHI) to submit a request for a correction. Your RHHI will forward this request to Medicare's Coordination of Benefits contractor to investigate and to make any necessary corrections.**

**You should note also that requests for anticipated payment (RAPs) cannot be correct or adjusted, only cancelled and re-billed. If Medicare is the secondary payer, the RAP will be processed for 0% payment. Additionally, if you are having problems with PC-ACE software, your should contact your RHHI. (03/02/01)**

Q8. When I try to access the Medicare Manual on your website, I get an error problem processing an SSI file. Is this going to be fixed? I have questions concerning MSP billing under PPS.

**A8. Your report of trouble accessing Medicare manuals on HCFA's website has been referred to the appropriate area, and was the first such complaint we have received. The manual files are usually very large, and at this time cannot be viewed on the website. At the URL:**

***http://www.hcfa.gov/pubforms/p2192toc.htm***

**You will find options to download the electronic manual OR order paper manuals.**

**In terms of HH PPS MSP changes, you will want to reference the Medicare Intermediary Manual, Chapter III Claims Processing, Section 3682. You may contact your Regional Home Health Intermediary, the Medicare Fiscal Intermediary processing home health claims for your area, for further information on this topic. (03/02/01)**

**Home Health (HH) Consolidated Billing:**

Q9. Are all providers, with the exception of durable medical equipment (DME) suppliers, being instructed to check CWF to verify that the beneficiary they are servicing is not under a Plan of Care, and therefore consolidated billing is not required? Or, is it the sole responsibility of the managed care organizations and Fiscal Intermediaries to make sure that consolidated billing requirements are being met?

**A9. The Common Working File or CWF-based inquiry system you refer to, one of two transactions known as either HIQH or HIQA providing information on home health episodes, is only available at the present time to providers who bill fiscal intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), on UB-92 or HCFA Form 1450 claim forms. Instructions relative to these systems appear in both the Medicare Intermediary and Home Health Manuals. HCFA is currently examining the feasibility of developing a comparable system for providers and suppliers, who bill carriers, including durable medical equipment regional carriers (DMERCs), on HCFA Form 1500 claim forms. While not required, we recommend providers who have access to this inquiry function use it.**

**Responsibility for enforcing home health consolidated billing law ultimately rests with HCFA. Since the scope of this law is cross-cutting, affecting both FI and carrier systems, most of the computer instructions or edits bringing about enforcement are executed in CWF, which can take action considering all billing for a beneficiary in a common period, whether claims are submitted to a FI or carrier systems. Some edits in CWF for home health consolidated billing have been in place since the legislative effective date of October 1, 2000, and others have been delayed. The edits that are now in place are being refined but will not be removed, and currently result in claims being sent back to providers, other than the primary home health agency opening the episode, if they contain services affected**

**by consolidated billing. In cases where automated enforcement is not yet in place, HCFA may either review claims post-payment, or run a special utility to capture services that were inappropriately paid, or both, in order to effect full enforcement going back to October 1, 2000. Since consolidated billing instruction are already out to providers, and include lists of services and supplies affected by HH consolidated billing, providers are already required to bill in compliance with the law. (03/02/01)**

Q10. If a patient presents to the hospital for physical therapy or other services that need to be billed to the HH provider, and the hospital does not have a contract with the HH provider, what are our options?

**A10. All Medicare providers have received information on the requirements of home health consolidated billing that went in to effect October 1, 2000. Providers delivering services that are part of the home health benefit should know to ask beneficiaries or their representative if they are or have recently received home care. If they bill such services and a home health episode is open in the same period, the hospital's claim will be rejected by Medicare fiscal intermediaries (FIs), though this claim can be re-billed removing the home health services, and will then be processed to payment. FIs have also been instructed that if contacted in consolidated billing situation, they may give providers information that will enable the providers to contact the other provider billing in the period.**

**All institutional providers who bill through Medicare fiscal intermediaries, including both home health agencies and hospitals, should also be using a Common Working File or CWF-based inquiry system, one of two transactions known as either HIQH or HIQA providing information on home health episodes. This system is much like the original HIQA system that provided eligibility information through the on-line claims standard system, either the Fiscal Intermediary Standard System (FISS) or Arkansas Part A Standard System (APASS). Instructions relative to these systems appear in both the Medicare Intermediary and Home Health Manuals. (03/02/01)**

Q11. Physical therapists in private practice (PTPPs) are receiving referrals for patients who have just been discharged from home health Part A services. The patients still need outpatient therapy services even though they are no longer homebound or eligible for the Medicare home health benefit. The PTPPs are treating them and then billing Medicare. The claims are being denied because the computer states that these patients are still eligible for Part A benefits and have not been discharged. The PTPPs have delayed billing their services so that the discharge can be processed on the Part A side. However, this is not helping. Is there something that the PTPP or the HHA can do to help resolve this matter?

**A11. Independent therapist claims and supplier claims can be accepted by Medicare systems for dates of service within a HH PPS episode, but after the date of discharge from the HHA. The episode is started by submission of a request for anticipated payment (RAP) that a HHA may submit as soon as they have provided a billable service. For Medicare systems to know the date of discharge, the claim for the episode must be received from the HHA.**

**Initially after the implementation of HH PPS there was an error in Medicare systems, which resulted in rejecting therapist and supplier claims in error, even when the HHA claim had been received. This error was corrected mid-January 2001, and this correction has relieved many of the long delays for therapists and suppliers.**

**Once a HH episode is open, the HHA claim must still be received before the therapist or supplier claim can be processed for services or supplies under home health consolidated billing within the episode period. Usually a short delay in billing by the independent therapist or supplier allows this to happen. In other cases, these providers or suppliers may contact the HHA to ascertain its billing status. (03/02/01)**

**Payment Adjustments:**

Q12. If a patient dies unexpectedly during a home health episode, will the agency receive the full episode payment including the therapy case mix if the patient has been seen by the nurse 7 times and by the therapist 6 times.

**A12. The final rule for HH PPS stated that if a beneficiary dies before the full 60-day episode is completed, Partial Episode Payment (PEP) adjustments will not apply. PEP adjustment would result in pro-ration of payment according to the percentage of days the patient served in the 60-day period (span of days from first to last billable visit). Therefore, in this situation, since only 6 therapy visits were provided, the episode payment would be adjusted assuming a HIPPS code was billed for the episode calling for 10 or more therapies, and that threshold had not been met. (03/02/01)**

Q13. Is the SCIC adjustment sample claim (sample claim #5) provided in Chapter VI of the HH PPS Training Manual calculated correctly? The last billable service date on the sample claim is November 10, 2000; however, the sample calculations provided use November 29, 2000 to calculate the span of days as a proportion of 60 for the second part of the SCIC adjustment. Do you use the last billable service date or the last day of the 60-day episode in SCIC adjustments?

**A13. You are correct then that the example of the SCIC adjustment in the Training Manual you refer to that is posted on the HCFA website (*www.hcfa.gov/medlearn/refhha.htm)* should have calculated payment from the last billable service date, not the end of the episode. We will issue a change to the Manual as soon as possible.**

**Significant Change of Condition (SCIC) adjustments to home health episode payments occur when at least one unanticipated and significant change in patient condition occurs during the course of the episode requiring both a reassessment of that patient and a change in original physician orders for home care. If there is one such change during an episode, there may be two HIPPS codes billed for the same episode, one representing the payment group before the change of condition, and the other the group after the re-assessment. Each payment group will be paid proportionately according to the number of days from and including the first billable service date under that HIPPS to and including the last billable service date under that HIPPS, not necessarily from the beginning or to the end of**

**the episode. For example, if billable services under the first HIPPS began with a visit October 15, and ended with a visit November 14 (30 days), and then services began under the second HIPPS began with a visit on November 20, and ended with a billable service November 24 (5 days), for an episode that went an entire 60 days (to November 29), 30/60 or ½ of the entire payment for the first HIPPS would be added to 5/60 or 1/12 of the entire payment for the second HIPPS for payment for the entire episode.**

**However, since the advent of HH PPS, HCFA has clarified that providers do not have to bill subsequent higher rate HIPPS codes for SCICs if they are in effect being financially penalized for continuing to serve a sicker patient under the SCIC ratio rule. The option such providers have is to bill just the first HIPPS, which would be paid at 100%, if this payment exceeds the combined proportionate payments that would be added together for the SCIC adjusted payment. When the SCIC is the result of a significant and unanticipated improvement, however, the SCIC must be billed. (03/02/01)**

Q14. Is there a therapy threshold with PEP and SCIC adjustments? Sample claims #4 and #5 in Chapter VI of the HH PPS Training Manual do not take into account that the input HIPPS codes on the claim indicates that 10 therapy visits should have been met. Because no therapy visits were made, the fallback code weight should be used.

**A14. You are correct that the HIPPS code used for illustrative purposes that you cite should have been supported by the delivery of ten or more therapy visits. We will issue a change to the Training Manual that is posted on the HCFA website (*www.hcfa.gov/medlearn/refhha.htm)* as soon as possible.**

**The therapy threshold for HH PPS episodes is ten or more therapy visits, and this threshold is applied to entire episodes, no matter what other adjustments, such as partial episode payment (PEP) or significant change in condition (SCIC) adjustments, apply. That is, a higher-paying HIPPS code would apply to episodes that are projected to have ten or more therapy visits, and this HIPPS code would only be downcoded because of this limit if nine or fewer therapies were actually provided over the course of the entire episode. Downcoding here means changing the HIPPS code to a parallel code that is paid less because nine or fewer therapies are anticipated/delivered. (03/02/01)**

**HH PPS Claim Elements, Questions 15-26:**

**Patient Status Codes:**

Q15. What is the patient status code when a patient has been discharged and then readmitted to the HHA before the end of the 60-day episode period? Some documentation states that the patient status would be 06, and others state that it is to be determined.

**A15. If a provider knows when billing a claim for an episode that the beneficiary has transferred to another provider in the 60 days that would have comprised a full episode, he or she should use patient status code 06, which represents transfer to another home health agency, on that claim. If a provider does not know a transfer has occurred in the 60-day**

**period, and does not use the patient status code that indicates this, the payment for his or her episode will nonetheless be cut back when the billing from the agency the beneficiary transferred to enters Medicare claims processing systems. The payment is cut back proportional to the number of days the beneficiary was served, a partial episode payment (PEP) adjustment. For example, if an episode began with a service delivered on October 1, and the last service delivered by this agency was October 14 (15 days) before the beneficiary transferred to another agency, this first agency would be paid 15/60 or ¼ of the entire HIPPS code for that episode. Note the HIPPS code represents the HHRG payment group for the episode, and is placed in Form Locator 44 of the claim.**

**If a significant change in condition (SCIC) adjustment has not been applied, and the provider bills a claim after the first discharge after goals were met knowing a subsequent unexpected admission has occurred in the same 60 days, the status code 06 would be most appropriately used, representing that a discharge and readmission, or "transfer to self", had occurred. As with the transfer to other provider situation above, if the provider sent in a claim after the first discharge, and did not know the beneficiary would be coming back in the same 60 days, Medicare systems will automatically cut back payment proportionately for the first episode.**

**Anytime a provider puts a patient status code 06 on a HH PPS claim, Medicare claim processing systems will apply a PEP adjustment to the episode the claim represents. Therefore, the 06 should only be used when more payment for home care will be made in the same 60-day period, not just when a beneficiary is discharged early in the episode and no other home care is delivered in the period. In this latter case, full episode payment should be made no matter the early discharge. However, use of this status code was incorrectly presented in the Training Manual on the HCFA website, and A correction request has already been made as follows:**

***HCFA has identified an error in the billing information available in our "Home Health Prospective Payment System Training Session" that is available on the Medlearn website (www.hcfa.gov/medlearn/refhha.htm).***

***Page 33 of Chapter Four of these training materials contains an error regarding the reporting of patient status codes in FL 22 of the UB-92 claim form. Currently Page 33 states:***

***" Enter the appropriate patient status code. If the beneficiary was discharged prior to the end of the 60-day episode, enter a patient status code of 06. If you are entering a patient status code of 20, note that the statement Through Date on the claim must be the date of death."***

***This entry should read:***

***" Enter the appropriate patient status code. If the beneficiary was discharged prior to the end of the 60-day episode and the goals of the plan of care are met use patient status 01. Patient status code 06 should be used on a final claim when the beneficiary has transferred from one agency to another home health agency (HHA) within an episode or when the patient is discharged prior to the end of the 60-day episode and the HHA knows the patient will be***

***readmitted within the same 60-day period. If you are entering a patient status code of 20, note that the statement Through Date on the claim must be the date of death."***

***HCFA will be making this correction to the Medlearn website in the near future.***

***HHAs may have submitted claims, which ended prior to end of the 60-day episode coded with a patient status code of 06 in situations that, were not transfers or discharges/readmissions. These claims will have received Partial Episode Payment (PEP) adjustments in error, reducing payment to the HHA. HHAs who discover this has occurred should submit adjustments (type of bill 3x7) to their claims, changing the patient status code to 01, in order to receive the balance of payment due for the episode. (03/02/01)***

Q16. I have a number of RAPs and final claims in the FISS system at status 6510, and with error code 425, reading: "DIS CODE UR - UTILIZATION REJECT CLAIM OVERLAPS AN EPISODE, ST NOT 06, SOA NOT B OR C". What do I need to do to fix these claims?

**A16. Requests for anticipated payment (RAPs) with this error code indicate that the beneficiary has been served by another home health agency within 60 days of your admitting them. For RAPs of a transfer agency to be accepted by the Common Working File, the source of admission code (SOA in the error message above: Form Locator 20 on the UB-92 or HCFA Form-1450 claim form) should be coded as a "B". This indicates the beneficiary is transferring within the episode already created by another provider.**

**Claims with this error code indicate that the beneficiary has been admitted to another home health agency within the 60-day episode created by your RAP, apparently indicating to your agency that the beneficiary has chosen to transfer. Patient status code 06, in Form Locator 22, should be used on HH PPS claims to indicate a transfer and that a partial episode payment (PEP) adjustment should be made to payment.**

**We recommend you begin by using the HIQA or HIQH inquiry systems to see if another episode is already on file for those beneficiaries. HIQH or HIQA will allow you to determine the start date of the new agency's episode, and adjust your claim "through" date (Form Locator 6) and overall dates of service as appropriate to the delivery of care. Such dates may be equal to, but not overlapping, the start date of the other agency's episode. If you were not aware of the transfer, payment for any services must be made under arrangement with the new agency, since they become the primary HHA by beneficiary choice.**

**If a significant change in condition (SCIC) adjustment has not been applied to the episode, and the provider bills a claim after the first discharge with goals met knowing a subsequent unexpected admission has occurred in the same 60 days, the patient status code 06 would be most appropriately used, representing that a discharge and readmission, or "transfer to self", had occurred. Also, when opening the subsequent episode with a RAP in this situation, a source code "C" would be used to indicate a transfer to self has occurred.**

**Finally, there is a current related problem in Medicare claims processing systems: in transfer situations, if the second agency has already filed its episode, and the first has yet to bill a RAP, when subsequently the first agency tries to bill a RAP, the first agency's RAP is being rejected. HCFA is currently working to fix this problem on an emergency basis. (03/02/01)**

Q17. What does a provider do if a Medicare patient is admitted by following Medicare certified guidelines that are conducive to home care, but the patient later, within this billing episode, becomes non-conducive for Medicare certified home health, i.e., is no longer homebound. However, the patient's secondary insurance, Medicaid, allows for services to billed for the patient, even though Medicare will no longer reimburse for the same services. In effect, the agency is not discharging the patient, but only doing a payer change.

What should the Medicare billing episode's final claim show as a claim status? Should the patient be "discharged" from Medicare, but not discharged at the agency level according to that agency's policies and procedures. Would the agency receive a full 60-day episode reimbursement amount?

If this same patient suddenly became homebound again (switched back to Medicare as primary within the original 60-day billing episode), wouldn't the Medicare billing episode still be active, or would a new episode start and the previous episode be "PEP'ed "after sending the final claim?

**A17. When Medicare ceases to be the payer for the services, the final claim should report a patient status code of 01 for "discharge to home/self care". This would ensure that the agency receives the full episode payment, with any appropriate payment adjustments, as long as no other Medicare home care is delivered in the same period, and Medicare systems update that the episode history in the Common Working File (CWF) to allow billing by suppliers or independent therapists.**

**If the patient returns to Medicare coverage unexpectedly within the 60-day episode, the agency would submit a new request for anticipated payment (RAP) with source of admission code "C", in Form Locator 20 of the claim, representing the patient returned to the same agency in the same 60 days. Upon receipt of this RAP, Medicare systems will automatically adjust the earlier final claim to reduce the payment to the appropriate Partial Episode Payment (PEP). We believe this would be a rare occurrence. (03/02/01)**

Q18. Our intermediary is recouping payment based on the number of days a client is on service. I have contacted the customer service department and they stand firm on their interpretation of the Federal Register. At this time I have a call into a supervisor that has not returned my phone call.

Here is an example of what they are doing. Our client comes on service Oct 1, 2000 and discharges from service Nov. 3, 2000. They are paying us the RAP and recouping once the claim is sent in and paying us the HHRG/60 times the number of days (in this example that would be 33 days) the client was on service. What they are doing is a PEP adjustment that does not meet the 3 intervening events. We should be paid at 100% of the HHRG.

**A18. It is difficult to determine the cause of the dispute described above from the limited information available in the question. Most likely, the final claim was submitted with a patient status code of "06" (indicating a transfer) in cases where the patient was simply discharged. All claims with patient status "06" are subject to partial episode payment (PEP) adjustment. Ensure that another appropriate patient status code indicating discharge is used on final claims, unless a transfer has actually occurred. Often the appropriate patient status code if a patient is discharged from Medicare home care would be 01, "discharge to home/self care".**

**HHAs may have submitted claims, which ended prior to end of the 60-day episode, and were coded with a patient status code of 06, in situations that were not transfers or discharges/re-admissions. These claims will have received Partial Episode Payment (PEP) adjustments in error, reducing payment to the HHA. HHAs who discover this has occurred should submit adjustments (type of bill 3x7) to their claims, changing the patient status code to 01, in order to receive the balance of payment due for the episode. (03/02/01)**

**Claim Through Date:**

Q19. I understand that a patient who remains in the hospital at the end of the 60-day episode must be discharged. On the final claim, what status code should be used, what should the Through Date be (last billable visit, date of transfer to hospital, or last day of episode), and will our agency receive a full episode payment or a PEP?

**A19. At the end of the episode you describe, the beneficiary has been discharged from home health care and admitted to a hospital. We believe that patient status code 05, "discharge/transfer to another facility", best describes this situation. The patient status code is placed in Form Locator 22 of the UB-92 (HCFA Form-1450) claim form. Other than patient status codes 06 or 20, specifically representing transfer to another home health agency and death, providers are free to use any valid patient status code they believe is appropriate to a given situation.**

**For the Through Date in this same scenario, follow your existing discharge practices. Usually, the date of discharge from home care would be the same day as the date of admission to the hospital. You will receive full episode payment since the patient is not receiving home care elsewhere during the same 60-day period. In general, the Through Date should be the date of discharge, which may or may not conform to the last billable service date in the episode. (03/02/01)**

Q20. What should HHAs do who have billing systems that do comply with the instructions in the final publication? Are those HHAs expected modify their agency billing systems to no longer print the last service date?

**A20. This question seems to refer to the change in Medicare billing instructions, to no longer require that the statement "through" date on the claim match the last line item service date. Since Medicare systems are no longer comparing these two dates to ensure**

**that they match, providers who are submitting matching dates can continue to do so. Claims will process whether the dates match or do not. In general, however, provider billing systems must be able to comply with Medicare billing instructions. (03/02/01)**

Q21. We submitted a batch of subsequent episode RAPs for those patients that had a start of care date as of 10/01/2000. The majority of the RAPs received had an error message in the FISS systems of "Line Item Date of Service is Outside From and Through Date". We noticed this because the visit was made on 12/05/00, and the subsequent episode RAPs have From and Through Dates of 11/30/00 - 11/30/00. Why is this happening, and what do we have to do to fix the RAPs so they can processed?

I checked the Home Health Prospective Payment System Book that we received at the training sessions, but I could not find anything in the book that spoke of this.

**A21. The question above refers to an error made in programming Medicare systems at the implementation of HH PPS. If you cancel and resubmit these requests for anticipated payment (RAPs), they should now process. (03/02/01)**

Q22. If last billable date is 12/28/00 and discharge date is 12/30/00, should the Through Date be 12/28/00 or 12/30/00? Please clarify.

**A22. The Through Date is reported in Form Locator 6 of the UB-92 (HCFA Form-1450) claim form. This should be the date of discharge for HH PPS claims. In the example above, it would be 12/30/2000. (03/02/01)**

**Metropolitan Statistical Area (MSA) Codes:**

Q23. I have not read anything regarding how we bill for MSA claims. Could you please help?

**A23. Metropolitan Statistical Area (MSA) codes, which were required prior to HH PPS on home health claims, represent the location where home health services were delivered. A MSA code appears with Value Code 61 in Form Locators 39-41 on the HCFA 1450 (UB-92) claim form. A list of MSA codes for HH PPS appeared in the final rule published July 3, 2000. Corrections were subsequently made to that list. Both the original list and the corrections to the final rule can be found on the HCFA website at: *www.hcfa.gov/medicare/hhmain.htm*. (03/02/01)**

**Clinical Claim Data:**

Q24. Can Occupational Therapy "OT" be the only discipline given to a HH PPS patient in the home? I realize OT cannot open a case, that is, a skilled service should be delivered first, but can they continue after physical therapy or Skilled Nursing are provided in the case?

**A24. Medicare home health services are comprised by six disciples: skilled nursing, physical therapy, occupational therapy, speech therapy, medical social services and home health aide services, all of which are delivered in the beneficiary's home. These services**

**are billed on the UB-92 or HCFA Form-1450 claim form in Form Locator 42 under the following revenue codes: skilled nursing (55x), physical therapy (42x), occupational therapy (43x), speech therapy (44x), medical social services (56x) and home health aide services (57x).**

**You are correct that there are qualifying skilled services which must be delivered in a period of care in order for Medicare home care to be covered-- this policy existed prior to HH PPS, and continues under that system. Services from all the categories above except medical social and home health aide services are considered qualifying services, but occupational therapy is only considered a qualifying service in a subsequent episode in a previous period of continuous care. OT cannot be the qualifying services for initial episodes.**

**Under HH PPS, a qualifying service must be delivered during an initial episode in order for the episode to qualify for Medicare coverage. If home care is continuous, that is at least one episodes follows (an) initial/previous episode(s) with no gaps in dates between episodes, those episode must also contain at least one skilled service. Additionally, occupational therapy may not serve as the qualifying skilled service in an initial episode, though it may serve as a skilled service in subsequent episodes in a period of continuous care. (03/02/01)**

Q25. If the Revenue Code 623 is used for wound care supplies, is an associated HCPCS code required? Home health bills have never required the HCPCS codes in the past, has this changed?

**A25. No specific HCPCS codes have been required to be billed with revenue code 623, which is now used in HH PPS billing to capture wound care supply costs. Supplies reported with this revenue code, however, should only be those used to treat the wound, not any supplies for the patient. HCFA has requested home health agencies voluntarily report wound care supplies in this manner so that the cost of such supplies can be studied as part of consideration of future rate adjustments. In general, HCPCS codes are only required in Form Locator 44 of Medicare HH claims: (1) to bill durable medical equipment, (2) to represent 15-minute increments of home health services. (03/02/01)**

Q26. My billing office said they spoke to a HCFA representative before Christmas, and they were informed that we will have to change OUR patient's medical record number for each new 60-day episode before we can file a RAP. Does there has to be a separate medical record number for each episode? This will be a time consuming task to discharge an electronic chart, and then readmit the patient for each subsequent episode. It the information our billing office received correct?

**A26. We believe there was a miscommunication as described above since Medicare does not require the reporting of a medical record number on claims. One of two numbers on the claim may actually be at issue. The patient control number reported in Form Locator 3 of the UB-92 claim form is an optional claims element. This is indicated in the Home Health Agency Manual in section 475.1. If a provider reports a patient control number, Medicare systems are required to carry this information through the complete processing of the claim. We have no other requirements for this number.**

**A separate Document Control Number (DCN) is generated by Medicare systems for each request for anticipated payment (RAP) and claim submitted. However, this number is used for internal tracking by in Medicare systems and is never generated by the provider. (03/02/01)**

**Other HH PPS Information, Questions 27-32:**

**Physician Certifications:**

Q27. A patient's certification dates are 10/08/00 to 12/06/00. The patient is seen 12/03/00 for a re-certification visit. On 12/04/00, the patient goes into hospital, and is discharged from hospital on 12/06/00. Can we resume care with a OASIS resumption of care (ROC) assessment, or must this patient be discharged and readmitted?

Scenario #2. Same as above, except the discharge occurred 12/07/00. Can we resume with ROC or must we discharge and readmit?

**A27. The beneficiary must be discharged if continuous episodes of care cannot occur because of the hospitalization, i.e., the patient is in the hospital at the point the 60-day episode period ends. If the beneficiary is discharged from the hospital on either 12/6/00 or 12/7/00, continuous episodes of care occur since the end of the first episode (Day 60) is 12/06/00 and the start of the new episode (Day 61) is 12/07/00. Therefore, the beneficiary does not need to be discharged and readmitted for billing purposes in either case. (03/02/01)**

Q28. Can you tell me what is the new code for physician payment for home health care plan oversight? And what is the new rate for California?

**A28. There are actually two new HCPCS codes for HH care plan certification:**

**G0180 - For certification**
**G0179 - For re-certification**

**These codes were published in HCFA Program Memorandum B-00-65 in November. This memo is available on our website at:**

***www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm.***

**For the rate in specific areas, contact your local carrier. These codes are exclusive to physician billing and are never reported by home health agencies. (03/02/01)**

**Provider Remittances:**

Q29. I have claims that seem to be paid incorrectly when I look at my remittance advice. In some cases, I have confirmed with my RHHI that incorrect payments were made. Among things

I see on these remittances is RAPs seem to be recouped, final claims paid half what they should be, an exorbitant negative contractual amount, but a correct amount in net reimbursement. Has a fix gone out to Medicare claims processing systems for these problems?

**A29. Since the advent of HH PPS, several problems have occurred with remittance advices, particularly the paper format, produced from the Fiscal Intermediary Standard System (FISS), which supports claims processing at the following RHHIs: United Government Services at either Wisconsin or California (formerly California Blue Cross), Palmetto in South Carolina or Cahaba (formerly Wellmark) in Iowa. This has been a cluster of problems, not a single problem, but can be broadly grouped in terms of payment effects.**

**HCFA is aware that some incorrect payments were made, involving either MSP, or non-covered services or adjustment claims were involved. These problems have all been fixed in FISS since mid-January, so they are no longer ongoing, but RHHIs are still working to identify any incorrect payments that were made before the corrections were installed. If you are certain you received incorrect payment, you should contact your RHHI and identify these payments.**

**The more typical situation involves payment which are not actually incorrect, but the remittance advise display is confusing and cannot be deciphered without referring either to the on-line claim system or calling the RHHI, FISS is still working to correct these display issues, which include confusing negative contractual amounts. HCFA, FISS and the RHHIs are continuing to work to install corrections as soon as possible.**

**Unfortunately, since this is such a broad problem and so many providers are calling the RHHIs, calls may be backlogged. Unless providers are certain their payments are incorrect, HCFA recommends you delay calling RHHIs unless operations are being adversely affected. HCFA is working with all the affected RHHIs to get out a centralized notice about this situation.**

**It should be noted that on normal remittance displays for HH PPS, request for anticipated payment (RAP payments) will be shown as being reversed or recouped with claims for the same episode, when these claims appear on remittances subsequent to those for the original RAPs. The net effect of the cancellation of the RAP will be that claim payment will be equal to the percentage of the episode remaining, either 50% or 40%, depending on the percentage that was received initially in response to the RAP. (03/02/01)**

**Calendar Year Billing:**

Q30. In the past charges could not cross calendar year and claims were split by month. Now with PPS, can episodes that cross calendar years be submitted all on one final episode claim or do charges have to be separated by calendar year? Example: Episode beginning 11/29/00 and ending 1/28/01.

**A31. HH PPS claims are represented as type of bill 32x or 33x on UB-92 or HCFA Form–1450 claim forms, in Form Locator 4, for Medicare home health service under a plan of care. Such claims contain all billing activity for a single episode of up to 60 days, and such an episode may cross a calendar year. That is, such claims DO NOT have to be separated by calendar year. However, most if not all other Medicare claims for institutional health services, including type of bill 34x for home health service NOT under a plan of care, must still be split by calendar year, so that the deuctible is calculated correctly each year. (03/02/01)**

**Change of Ownership (CHOW):**

Q31. What happens to the episode payment when a beneficiary changes home health agencies during a 60-day period, perhaps because one agency was purchased by another agency? Would the initial HHA bill and be adjusted as a Partial Episode Payment (PEP)? Would the second agency then begin a new 60-day episode period?

**A31. The purchasing agency that chooses to obtain a new provider or OSCAR number [OSCAR numbers are the first six digits of the Medicare provider number for institutional providers with longer numbers] needs to submit new request for anticipated payment (RAP) creating a new 60-day episode period on the date from which the provider number becomes effective. All pre-existing episodes under the old OSCAR number should be submitted with the patient status code 06, "discharged/transferred to home/under HHA care", placed in Form Locator 22 of the UB-92 (HCFA Form-1450) claim. These agencies will receive partial episode payment (PEP) adjustments for these previous episodes, so that the episode "clock" is re-set with billings under the new OSCAR number. However, if the purchasing agency assumes the original OSCAR or provider number, billing is uninterrupted. (03/02/01)**

**HCFA Website:**

Q32. Where is the site which details the most frequently asked questions on Home Health Prospective Payment and the associated answers?

**A32. In addition to this site, other HH PPS questions and answers are available at *www.hcfa.gov/medicare/hhmain.htm*. (03/02/01)**